North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

TYPHOID, CARRIER (SALMONELLA TYPHI)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 144

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):_____
Fatigue or malaise or weakness ☐ Y ☐ N ☐ U
Sweats (diaphoresis) ☐ Y ☐ N ☐ U
Night sweats ☐ Y ☐ N ☐ U
Headache ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Diarrhea ☐ Y ☐ N ☐ U
Describe (select all that apply)
☐ Bloody ☐ Non-bloody
☐ Watery ☐ Other
Maximum number of stools in a 24-hour period:_____

REASON FOR TESTING

Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household / close contact to a person reported with this disease
☐ Prior positive test
Positive test date_____
☐ Other, specify_____
☐ Unknown

TREATMENT

Did the patient take an antibiotic for this illness? ☐ Y ☐ N ☐ U
Specify antibiotic name: _____
Date antibiotic ended: _____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____
_____
Survived? ☐ Y ☐ N ☐ U
Died? ☐ Y ☐ N ☐ U
Died from this illness? ☐ Y ☐ N ☐ U
Date of death (mm/dd/yyyy):_____/_____/_____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify
_____
Date control measures issued: _____
Date control measures ended: _____
Was patient compliant with control measures? ☐ Y ☐ N
Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N
If yes, specify: _____
_____
Were written isolation orders issued? ☐ Y ☐ N
If yes, where was the patient isolated? _____
_____
Date isolation started? _____
Date isolation ended? _____
Was the patient compliant with isolation? ☐ Y ☐ N

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient have a travel history during the 4+ months after acute typhoid fever onset? ☐ Y ☐ N ☐ U

List travel dates and destinations _____

_____

_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

List persons and contact information:

_____

_____

_____

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student? ☐ Y ☐ N ☐ U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 4+ months after acute typhoid fever onset did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐ Y ☐ N ☐ U

Name of facility:_____

Dates of contact: _____

During the 4+ months after acute typhoid fever onset, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify:_____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify:

FOOD RISK AND EXPOSURE

During the 4+ months after acute typhoid fever onset, was the patient:

Employed as food worker? ☐ Y ☐ N ☐ U

Where employed?_____

Specify job duties:_____

What dates did the patient work?

_____

Employed as food worker while symptomatic? ☐ Y ☐ N ☐ U

Where did the patient work? _____

What dates did the patient work?

_____

What day did the patient return to food service work?

Date: _____

Where did patient return to work?_____

Anon-occupational food worker? (e.g. potlucks, receptions) during contagious period ☐ Y ☐ N ☐ U

Where employed?_____

Specify dates worked during contagious period:

_____

A health care worker or child care worker handling food or medication in the contagious period ? ☐ Y ☐ N ☐ U

Where employed?_____

Specify dates worked during contagious period:

_____

Comments:

VACCINE

Has patient / contact ever received vaccine related to this disease? ☐ Y ☐ N ☐ U

Vaccine type:_____

Date last dose received (mm/dd/yyyy):_____

Source of vaccine information:
- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record
- ☐ Certificate of immunization record
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify:_____
- ☐ Unknown

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes regarding setting of exposure:

Typhoid, carriage *(Salmonella typhi)*

2007 Case Definition (North Carolina)

Clinical description

Must be currently asymptomatic with a history of acute illness caused by *Salmonella typhi*

Laboratory criteria for diagnosis

- Isolation of *S. typhi* from blood, stool, or other clinical specimen at least three months after onset of symptoms in a person with a confirmed case of Typhoid Fever, acute

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Isolation of the organism is required for confirmation. Serologic evidence alone is not sufficient for diagnosis. Asymptomatic carriage should be reported as Typhoid, carriage to the Division of Public Health so that cases can be monitored under isolation orders. Typhoid, carriage cases are not reported to CDC.

See also Typhoid Fever